CARROTS AND STICKS: FEDERAL-PROVINCIAL FISCAL RELATIONS AND ENFORCEMENT OF THE *CANADA HEALTH ACT*

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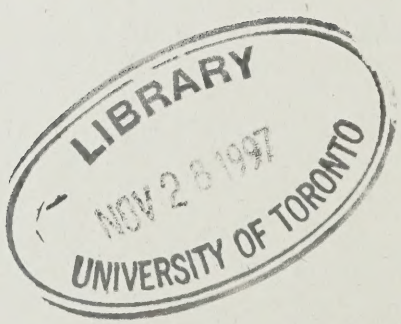

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INTRODUCTION

Since 1957 and the advent of cost-sharing for hospital care, the federal government has had a major role in health care policy, in spite of its being a provincial responsibility under the Canadian constitution. For 20 years, the carrot was the motif of federal-provincial relations in health care, as provinces were rewarded with "50-cent dollars" under federal cost-sharing if they provided new programs.[1] In the late 1970s the federal government moved to block grants rather than specific cost-sharing, a fiscal decision that led directly to the political necessity for the *Canada Health Act*. Block grants gave the provinces more autonomy, but the Act allowed the federal government to use a stick, the threat of withdrawal of its cash grants for health care to influence specific provincial health policies, if the federal government decided those policies violated the principles of public health insurance. In this decade, a nominal freeze on federal cash transfers for health led the Mulroney government to pass a law in 1991 allowing the federal government to withhold any federal transfers, not just those for health, to enforce adherence to the Act. Most recently, real cuts planned under the Canada Health and Social Transfer will profoundly affect the federal government's ability to influence provincial health policy. Over the next 10 to 15 years, federal cash transfers for health and social assistance are likely to drop to zero; in the absence of a federal carrot or stick, will the provinces continue to follow the health policy route mapped out by the *Canada Health Act*?

EARLIER LEGISLATION

The province of Saskatchewan pioneered publicly-funded hospital insurance in the late 1940s, and comprehensive health insurance in the 1960s. The lessons of the Saskatchewan experience inspired the relevant federal acts, the *Hospital Insurance and Diagnostic Services Act* of 1957 and the *Medical Care Act* of 1966, which launched federal-provincial cooperation in the provision of health care to Canadians. Under the first Act, negotiated between the federal and provincial governments from 1955 to 1957, the federal government covered 50% of all in-patient and out-patient hospital services, but did not cover mental hospitals, sanatoria or nursing homes. It was a universally available benefit, administered by provinces, and had no limits on days of care. The cost-sharing formula encouraged provinces to provide hospital care at below the national average rates (since they would then in effect get slightly more than 50% of insured services

reimbursed), and stated that capital and interest costs would not be cost-shared. It also encouraged provinces to "license, inspect and supervise" the operation of hospitals, and gave provinces and hospitals assurances that the latter would continue to exist as independent non-profit corporations.[2] By 1961, every province and territory was participating in the program, and by 1963, 98% of the population of Canada was insured and could receive publicly funded hospital care (though both Alberta and British Columbia had per diems, which were not forbidden under the Act).[3]

In 1961, in the wake of the success of the hospital plan and the development of a medicare law in Saskatchewan (though full public health insurance was not yet in place), Prime Minister Diefenbaker appointed a Royal Commission on Health Services to examine the idea of public health insurance. It strongly recommended the introduction of a cost-shared program, on the model of the hospital plan, to allow the provinces to provide "comprehensive, universal, provincial programs of personal health services." However, the *Medical Care Act* which was eventually introduced by a Liberal federal government was a good deal more contentious than the hospital plan. The assurances the federal government could give to hospitals, of retaining a substantial degree of independence within global budgets, were less appealing to physicians, and medical associations bitterly opposed the program as it was introduced federally and in each province. It was a cost-shared program with four guiding principles: comprehensiveness (all medical services), universality (all citizens), public administration (accountability for federal money received) and portability (among provinces).[4] The Act was proclaimed in December 1966, and by 1971 all provinces had joined the program (by April 1972 both Territories had done so).

Quebec

Quebec was one of the last provinces to sign on to the federal-provincial program, though its own Royal Commission, headed by Claude Castonguay, had strongly recommended adoption of a publicly financed system. The Union Nationale government had introduced a bill early in 1970 financing its program with a combination of income and payroll taxes, and providing that the patients of doctors who opted out of the program could not be reimbursed for any of their medical costs by the province. In the wake of the spring 1970 election, the new Liberal Minister of Health Mr. Castonguay introduced a revised bill, which had similar provisions on opting out and established a board to mediate disputes between the government and individual physicians.

The specialists' federation voted in August to strike starting in October 1970, but were ordered back to work, an event overshadowed by the FLQ crisis occurring at the same time. Under the back-to-work bill, doctors could:

- bill the province directly for services, but could not then extra-bill patients;
- could bill their patients at the level of the fee schedule and patients would then be reimbursed by the province; or
- if they charged patients more than the provincial fee schedule for services, their patients would receive no reimbursement from the province.

In the wake of this bill, Quebec formally joined the national program in November 1970.

FEDERAL TRANSFERS IN AN ERA OF CONSTRAINT

Established Programs Financing

In 1978, federal transfers for health and post-secondary education stopped being an open-ended 50% of whatever provincial governments paid for these items (or at least those recognized as legitimate by the federal government)[5] and moved to a block grant system (EPF, or Established Programs Financing). Under this, the benchmark spending of 1977 would increase with population and GDP, but not with provincial policy decisions to spend more in these areas. This made for a more predictable increase in federal transfers; in return, the provinces escaped from micro-management of programs constitutionally under their own jurisdiction and could spend these block grants however they wished. It should be noted, though, that in the high inflation era of the early 1980s, federal cash transfers for health care went from $4.7 billion in 1977-78 to $8.5 billion in 1982-83, while total provincial spending more than doubled (to $21.5 billion).[6]

In an innovation that would come to have greater policy significance in recent years, the federal government gave part of this transfer in tax points (that is, they charged less federal tax and made room for the provinces to take up that sum in provincial income tax). The federal government dropped personal income taxes by 13.5% and corporate income tax by one point, leaving the provinces free to take up that tax room, as they did. In fact, the federal government had offered to provide some transfers in the form of tax points in the 1960s, but at

that time only Quebec took up the offer; for that reason, it receives an additional 16.5 tax points over and above the 13.5 it received in 1977.[7] The effect of this approach is that the total transfer to provinces is calculated, then the amount they receive from the tax points is subtracted from that, and the residual amount is a cash transfer from the federal government. Because the value of tax points increases over time, if the total transfer entitlement is constrained or frozen, the residual cash transfer will shrink over time.

EPF provided increased flexibility for provinces, as it was intended to. But, as discussed below, some of the policy changes that resulted, most notably tolerance of extra-billing and user fees, were perceived by the federal government as posing a threat to public health insurance itself. That concern led directly to the *Canada Health Act* (see below). However, in the short term, the federal government found that a block grant system gave it a good deal of political room to restrict transfers, while leaving decisions on where cuts would actually occur (and the resulting opprobrium) to the provinces. The 1977 arrangements, which envisioned predictable increases in the cash transfer and ordinary increases in the tax portion, were soon restricted by the Trudeau and Mulroney governments.

- In 1982, the overall amount provinces were entitled to was altered to reflect increases in population; the portion received as taxes (from the tax point transfer) was subtracted from the total amount and the residual amount was received as cash from the federal government. This launched the process discussed above: the value of tax points tended to increase faster than the overall EPF transfer, so the cash transfers started to decline.

- In 1984 and 1985, increases in the post-secondary component of EPF were limited under the federal government's anti-inflation program to 6% in the first year and 5% in the second year of the program.

- In 1986, the rate of annual increase in EPF transfers was limited to the increase in GDP less two percentage points.

- In 1990, the transfers were frozen; this freeze was extended in the 1991 budget to 1994, at which point increases would be limited to the increase in GDP less three percentage points.[8]

- In the 1995 budget, the effective end of EPF has been announced: federal money for health, post-secondary education and social assistance (previously delivered under a separate program, the

Canada Assistance Plan) will be rolled into one block grant, the Canada Health and Social Transfer (CHST). The absolute amount of this cash transfer will be reduced over the next two years — from $17 billion for CAP and EPF in 1995-96 to $10 billion in 1997-98[9] ($3.6 billion of those cuts will be made in transfers to Ontario).[10]

Policy Changes in the Provinces

To return to 1977, however, once the provinces were free of the administrative restrictions of the earlier health acts, a number of problems developed. Most significant were the proposals for user fees in some provinces, and the increase of extra-billing by doctors in most provinces. The amount, extent and exceptions to extra-billing in individual practices varied: in Ontario, over 10% of physicians opted out (that is, billed patients directly rather than billing OHIP) but only about 5% extra-billed above OHIP rates; in Nova Scotia about 53% of physicians extra-billed patients; in Alberta about 47% of physicians did so. In 1983 the Alberta Minister of Health authorized hospitals to collect daily user fees, though none did so.[11]

Decades of public policy research in Canada and the U.S., as well as specific studies in the late 1970s in provinces where extra-billing was common, have demonstrated that both user fees and extra-billing:

- do not deter unnecessary care;
- do deter some people, particularly poor and elderly people, from seeking timely care;[12] and
- tend to increase costs overall, though they have the effect of shifting costs from public to private payers.[13]

The federal Minister, Monique Bégin, argued in the 1979 election campaign, and after her return to office, that the provinces were misusing federal EPF funds (though, in fact, in the wake of the 1977 changes there were no longer federal conditions on this spending, as the minister herself later acknowledged), and that extra-billing and user fees would create a two-tier health system (a more accurate claim).

The Hall Report, 1980

In the wake of the 1979 campaign, the new Conservative government appointed Justice Emmett Hall, who had chaired the original Royal

Commission recommending the establishment of national health insurance, to examine the state of health services in Canada. His report was made in 1980 to the returned Minister Bégin. He found that the Minister's allegation that health dollars had been "diverted" by the provinces under the 1977 arrangements was not established. He also concluded that the practice of extra-billing and user fees would create a two-tier system of health care and would ultimately destroy the public tier of that system. However, he argued that physicians are "entitled to be adequately compensated," and specifically that provinces ought not to unilaterally decide on physician compensation. He therefore recommended that the *Medical Care Act* be revised to provide:

- that extra-billing by physicians inhibits reasonable access to services and is contrary to the intent and purpose of the Act; and
- that the provinces should develop a mechanism [specifically, binding arbitration in the absence of an agreement on the fee schedule] to ensure reasonable compensation to physicians.[14]

He also made a number of other recommendations intended to move the system into greater adherence to the principles of medicare: on portability of benefits between provinces, user fees in hospitals, and health insurance premiums.

A House of Commons task force recommended in 1981 that any provincial health plan "that does not meet fully all the accessibility criteria [of the *Medical Care Act*] be ineligible for full federal financial support under Established Programs Financing."[15] Thus both the policy issues and the route to federal enforcement of the principles of public health insurance had been clearly laid out by important reports, written after extensive consultation. Over the next three years the Minister consulted with interest groups and commissioned a white paper and studies on the effect of user fees. The Hall report especially had a major influence on the ultimate form of the *Canada Health Act*; partly because Hall had been commissioned by the Conservative government, the Act was in the end supported by the Conservative party as well as the governing Liberals. Though she faced resistance in Cabinet and the provinces, as well as from physicians' organizations, the *Canada Health Act* received unanimous support in the House of Commons in 1984 and was proclaimed in that year.[16]

THE *CANADA HEALTH ACT*

The Act repeated the guiding principles of medicare in Canada: universality, accessibility, comprehensiveness, portability among provinces, and public administration. However, in the absence of the pre-1977 model of administrative control over how provinces spent cost-shared dollars, the Act allowed the federal government to withhold portions of its cash transfers under EPF. Specifically in response to the extra-billing issue, it allowed the federal government to withhold a dollar in transfers for every dollar extra-billed by doctors, or every dollar collected in hospital user fees (that is, daily fees for basic care, rather than private rooms, etc.) in a given province. However, it gave provinces three years to bring their insurance systems into line with the Act (s. 20(4)); any money withheld between 1984, when the Act came into force, and 1987, would be reimbursed if the province was no longer in violation of the Act by 1987 (s. 20(5).

The Act also carefully defined each of the principles and laid out a process of federal-provincial negotiation if the federal government believed a province's policy was violating the Act. If the federal minister believes that a province is in violation of the Act, s/he must send the provincial minister a notice of concern, seek discussions with the provincial minister, and report back to the provincial minister within 90 days as to whether the federal government believes a violation exists. The federal minister must meet with the province to discuss this report if the province wishes to do so, though the federal government can act unilaterally if the province refuses to meet on the issue (s. 14). The federal Cabinet may then order that funds be withheld and may vary the amount withheld, and must notify the province of this decision (s.15).

ENFORCEMENT OF THE ACT

Extra-Billing

The effective three-year window for provinces to adhere to the Act meant that the years 1984 to 1987 were busy ones in federal-provincial health issues. The first province to ban extra-billing was Nova Scotia, after it negotiated a provision for "final offer" arbitration (an arbitrator picks one of the two final offers made by the province or doctors). By 1985 Saskatchewan had negotiated a "Quebec model" settlement with its doctors: as noted earlier, they could be paid directly by the province and not extra-bill, bill their patients at the level of the fee

schedule and patients would then be reimbursed, or if they charged more than the fee schedule, their patients would receive no reimbursement from the province. Manitoba physicians agreed to end extra-billing, to pay compulsory dues to the Manitoba Medical Association, and to use binding arbitration to settle disputes over the fee schedule; in August 1985 the province received $1.27 million that had been withheld by the federal government. In Ontario, after a 25-day doctors' strike in 1986, the *Health Care Accessibility Act* banning extra-billing has been enforced with little debate. Alberta ended extra-billing by its doctors with a series of concessions tending to increase their incomes: increases to the fee schedule, a new fee for "extraordinary" services not on the schedule, binding arbitration in the absence of agreement on the schedule, and the "Quebec option" of complete opting-out by doctor and patient. New Brunswick was the last province to ban extra-billing, in an agreement taking effect on March 31, 1987.[17]

1994 Negotiations with British Columbia

In April 1994, the federal Minister informed the B.C. government that fees extra-billed by 41 physicians would be withheld from the province's transfer payments starting in May. The physicians had opted out of the B.C. Medical Services Plan and billed their patients directly, but they billed more than the fee schedule and their patients received partial reimbursement from the government.[18] This violated the Quebec option acceptable under the CHA. In May 1994 the minister withheld $1.75 million of the $62 million monthly payment to B.C. under EPF. In June 1994 a resolution of the issue was announced by the Minister of Health and the B.C. Medical Association, a resolution facilitated by the fact that the minister objected to the extra-billing as strongly as the federal minister. However, not all of the extra-billing doctors have followed the agreement, and a few continue to extra-bill. As of June 1995, approximately $10,000 a month is still being withheld by the federal government under the Act, for a total of some $1.985 million since May 1994.[19]

Private Clinics

Settlement of federal-provincial tensions over private and semi-private clinics is likely to take much longer and be much more contentious. With the increase in surgical services that can safely be performed outside hospitals, the opportunity for profitable clinic provision of insured services arose. Eye operations and abortions are only the most

visible of the services that are being performed outside hospitals, where doctors can bill provincial health insurance for performing procedures, and have been billing individuals a "facility fee" as well. The federal government has been arguing since 1994 that this latter fee violates the accessibility provisions of the CHA in the same way that extra-billing by doctors does, and is liable to the same penalties under the Act. The federal minister, Mme. Marleau, has written to the provinces who allow private clinics saying that money will be withheld under the Act if this situation is not remedied by October 1995.[20]

The Ontario government introduced the *Independent Health Facilities Act* in 1988 to address the question of facility fees long before the federal government believed that such fees violated the CHA. Under the Ontario law, proposals for clinics have to demonstrate a need for their services (or the Ministry of Health invites proposals if it has found a need); once a clinic is approved, it receives an annual operating budget from the ministry. Facility fees cannot be charged to individuals in any circumstances if they are receiving insured services.[21]

British Columbia has announced that it will regulate private clinics in that province, thus avoiding any cash penalties; its policy is intended to provide direct control over the number and type of clinics and ensure that patients face no extra charges.[22] Alberta, on the other hand, has been intransigent, arguing that the existence of private clinics takes pressure off hospitals and does not violate the federal Act.[23]

NON-ENFORCEMENT OF THE ACT

Quebec Policy on Physician Payment

The province of Quebec has always refused, with few exceptions, to pay physicians in other provinces at the rates of those provinces' fee schedules, though it does reimburse them at Quebec rates. Since the latter tend to be lower, the province saves money, but *de facto* portability of services for residents of Quebec is threatened. The other provinces signed a reciprocal medical billing agreement in the late 1980s, allowing reimbursement at host-province rates to physicians providing care out-of-province. Quebec never signed this agreement, though it negotiated bilateral agreements with Ontario on physician reimbursement in particular areas where serious problems had developed.[24]

Out of Country Services

The Act quite clearly says that services paid out of country must be paid at the same rate they would be paid in the home province of the person who receives the services, though the public policy rationale for this is obscure. In theory, federal funding can be used to enforce portability of benefits between provinces, in an area of provincial jurisdiction, because it is collected from all Canadian taxpayers. However, the collective benefit of portability to jurisdictions where Canadian taxpayers have not shared in the cost of services is much less clear. Whatever the rationale for the requirement, however, it is in the Act, and in spite of it, B.C., Saskatchewan, Alberta and Ontario have cut the amount of money they will provide, even for emergency care, when it is performed outside Canada.[25] The federal minister has stated that she is concerned that these changes violate the federal Act, but has not pursued the issue as a priority.[26]

Delisting of Services

A less contentious route to saving money, and one followed by most provinces, has been to "delist" particular services (i.e., remove them from the list of procedures they will pay health professionals to do). Since the *Canada Health Act* does not define "medically necessary services," or "comprehensive," provinces have been free to do this with little immediate protest from the federal government. Some actions have been politically untenable, and could potentially have been challenged under the Act, though others have been taken after consultation as to the medical necessity and effectiveness of particular procedures.

The most notable of these delisting decisions was the 1987 announcement by the Alberta government that it would stop paying providers for vasectomies, tubal ligations, IUD insertions, artificial insemination and contraceptive counselling, as well as contact lens fittings, some coverage of podiatric, chiropractic and physiotherapy care, and eye exams for adults.[27] Though the Alberta Medical Association had been negotiating with the province on the list of insured services, the Association had not suggested or been consulted on the delisting of contraceptive counselling and eye exams. Studies found hardship among women seeking contraception, and increased pressure on family planning clinics.[28] Coverage of sterilization procedures and IUD insertions was reinstated in April 1988, and the government restored coverage of most of the other procedures in June

of that year (though eye exams were limited to one every two years under public insurance).[29]

More recently, the province, along with most others, has been negotiating a list of "non-essential" services with the province's medical profession. Some policy analysts would argue that this approach to cost-control is ineffective or inappropriate, but attacks on this approach are not likely to come via the *Canada Health Act*. Historically the federal government has avoided such detailed management of the provincial health systems as providing a list of "insured services" that provincial health plans are obliged to pay for. The debate on deinsuring, therefore, is likely to take place at the provincial level, as it did in the late 1980s in Alberta.

THE END OF THE *CANADA HEALTH ACT*?

With the changes to Established Programs Financing to allow for increases less than the increase in GDP, it became clear some years ago that cash transfers would eventually fall to zero. As a result, the federal government's ability to enforce the principles of the Act would disappear, even if the law remained on the books. The Mulroney government therefore passed a bill allowing the federal government to withhold transfers under other programs, particularly the Canada Assistance Plan, if the principles of the *Canada Health Act* were violated. In the 1990 budget, however, increases to transfers under the Canada Assistance Plan to the three "have" provinces were "capped" at 5% per year. As a result of the cap, British Columbia now receives about a third and Ontario receives about 28% of their social assistance costs from the federal government (all other provinces receive 50% of eligible social assistance costs), so this tool was also gradually being eroded for some provinces.

However, the 1995 federal budget introduced the Canada Social Transfer (since renamed the Canada Health and Social Transfer), a block grant replacing both EPF and CAP, and announced sharp drops in cash transfers under this grant over the next two fiscal years. This will accelerate the process of federal cash transfers dropping to zero, an event now expected early in the next century. Until that happens, the federal government can use its cash transfers to provinces to enforce the *Canada Health Act*. However, with the carrot of increased federal funds for health services long gone, and the stick of withholding cash transfers losing its effectiveness, federally-enforced health policy will be replaced by either greater provincial cooperation

on appropriate actions, or 12 increasingly different health insurance regimes across the country.

The Group of 22, for example, a non-governmental group working on constitutional issues in the aftermath of the failure of the Meech Lake Accord, recommended that the federal government transfer all health funds to the provinces, appropriately equalized, and that national standards should be monitored by a constitutionally enshrined interprovincial monitoring agency.[30] While this body would not be able to force compliance with the generally acceptable principles of the CHA, the recommendation is suggestive in that the absence of federal cash transfers will create the same *de facto* situation, without any structures to protect those principles. The Canadian Bar Association has recommended that provinces (other than Quebec, which has already done so) legislate a right to health care and define the terms "medically necessary" and "medically required," to prevent delisting from depriving people of essential medical care.[31]

The provincial Ministers of Health agreed in the communique from their 1995 meeting that they need to work with the federal government towards a clear interpretation of the *Canada Health Act* to avoid "diverse understandings of insured services," and a patchwork system of health services across the country; though at the same meeting the Quebec Minister argued that the federal government should withdraw completely from policy control over health and other established programs, providing all funding through the transfer of tax points.[32] Whatever arrangements develop, under current fiscal plans and trends, the *Canada Health Act* will cease to have the importance it has enjoyed over the last 11 years in Canadian health policy. If the Act's broad principles are to be maintained, the federal government, provinces and interested Canadians will need to consider what rules and standards should replace it, and how they might be enforced.

NOTES

[1] Though it should be noted that there was never a straight 50% cost-sharing of every provincial initiative; as noted below, there were some incentives for provinces to provide care at below the national average cost.

[2] The act is discussed in detail in Canada, Royal Commission on Health Services, (Emmett Hall, Commissioner), *Report* (Ottawa: Queen's Printer, 1964), vol. I, pp. 411-413.

[3] Ibid., pp. 416, 415.

[4] Malcolm G. Taylor, The Institute of Public Administration of Canada, *Health Insurance and Canadian Public Policy: The Seven Decisions That Created the Canadian Health Insurance System and Their Outcomes*, 2nd. ed. (Kingston and Montreal: McGill-Queen's University Press, 1987), p. 365.

[5] As with the Canada Assistance Plan, the administrative details of federal cost-sharing tended to stifle innovation in delivery.

[6] Thomas Courchene, *Social Policy in the 1990s* (Scarborough: C.D. Howe Institute, 1987), Tables 18 and 20.

[7] Thomas Courchene, *Social Canada in the Millennium* (Toronto: C.D. Howe Institute, 1994), pp. 109-115.

[8] Kenneth Norrie, "Social Policy and Equalization," in *The Future of Fiscal Federalism: Proceedings of a conference held at Queen's University, November 4-5, 1993*, Keith Banting et al., eds. (Kingston: School of Policy Studies, 1994), pp. 162-163, provides a useful summary of developments in EPF.

[9] Canada, Department of Finance, *Budget Plan 1995* (Ottawa: Department of Supply and Services, 1995), p. 51.

[10] Ontario, Ministry of Finance, *1995 Ontario Budget Plan* (Toronto: Queen's Printer for Ontario, 1995), p. 5.

[11] *Health Insurance and Canadian Public Policy*, pp. 437,439.

[12] The most recent evidence I have found showing this effect, though it fails to break down care into "needed" or "unneeded," is Scott Kupor et al., "The Effect of Copayments and Income on the Utilization of Medical Care by Subscribers to Japan's National Health Insurance System," *International Journal of Health Services* 25:2 (1995): 295-312.

[13] The House of Commons Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women (in *The Health Care System in Canada and its Funding*,

tabled June 1991, pp. 31-32) did a comprehensive literature search in the field and found no evidence or research that was favourable to user fees as an effective deterrent of unneeded care.

[14] Canada, Health Services Review '79, *Canada's National-Provincial Health Program for the 1980's* (Saskatoon: The Review, 1980), pp. 27-29.

[15] Quoted in *Health Insurance and Canadian Public Policy*, p. 433.

[16] Monique Bégin, *Medicare: Canada's Right to Health* (Ottawa: Optimum Publishing International Inc., 1988), pp. 117-120

[17] Taylor, pp. 446-462.

[18] Rod Mickleburgh, "Ottawa gets tough over B.C. extra-billing," *Globe and Mail*, 23 April 1994, p. A1; British Columbia, Ministry of Health, "Health Minister and the BCMA agreement on extra-billing doctors", *News Release*, 24 June 1994, p. 1.

[19] Telephone interview with Bruce Davis, Health Insurance Branch, Health Canada, 20 June 1995.

[20] Christopher Serres, "Marleau issues her ultimatum," *Alberta Report* (23 January 1995), p. 12.

[21] Of course many uninsured services, such as cosmetic surgery, are provided in private clinics.

[22] Miro Cernetig, "B.C. to ban user fees," *Globe and Mail*, 10 January 1995, p. A1.

[23] Christopher Serres, "Why no one listens when the minister speaks," *Alberta Report* (18 December 1994), p. 8.

[24] "Ottawa cleans up act," *Medical Post*, 5 July 1994, pp. 1, 6.

[25] Milan Korcok, "Provinces have been breaking Canada Health Act for years," *Globe and Mail*, 12 May 1994, p. A25.

[26] "Ottawa cleans up act," *Medical Post*, 5 July 1994, pp. 1,6.

[27] Ann Silversides, "Scheme to cut medical aid assailed," *Globe and Mail*, 23 May 1987.

[28] Robert Walker, "Report criticizes medicare changes," *Calgary Herald*, 4 March 1988, p. B2.

[29] Ashley Geddes, "Moore restores health cuts," *Calgary Herald*, 30 June 1988, p. A1.

[30] Group of 22, *Some Practical Suggestions for Canada* (Montreal: Le Groupe Columbia, inc., June 1991), p. 17.

[31] The Canadian Bar Association Task Force on Health Care, *What's Law Got To Do With It? Health Care Reform in Canada* (Ottawa: The Association, 1994), pp. 40-41.

[32] "Provincial/territorial health ministers call for clarification of partnership role with federal government in health care," *Press Release*, 11 April 1995, p. 2; Government of Quebec, Ministry of Health and Social Services, Minister's Office, "Jean Rochon reaffirms Quebec's exclusive jurisdiction over the health sector," *Press Release*, 11 April 1995.

CHAPTER C-6

An Act relating to cash contributions by Canada in respect of insured health services provided under provincial health care insurance plans and amounts payable by Canada in respect of extended health care services

WHEREAS the Parliament of Canada recognizes:

—that it is not the intention of the Government of Canada that any of the powers, rights, privileges or authorities vested in Canada or the provinces under the provisions of the *Constitution Act, 1867*, or any amendments thereto, or otherwise, be by reason of this Act abrogated or derogated from or in any way impaired;

—that Canadians, through their system of insured health services, have made outstanding progress in treating sickness and alleviating the consequences of disease and disability among all income groups;

—that Canadians can achieve further improvements in their well-being through combining individual lifestyles that emphasize fitness, prevention of disease and health promotion with collective action against the social, environmental and occupational causes of disease, and that they desire a system of health services that will promote physical and mental health and protection against disease;

—that future improvements in health will require the cooperative partnership of governments, health professionals, voluntary organizations and individual Canadians;

—that continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians;

CHAPITRE C-6

Loi concernant les contributions pécuniaires du Canada aux services de santé assurés pris en charge par les régimes provinciaux d'assurance-santé et les montants payables par le Canada pour les programmes de services complémentaires de santé

Considérant que le Parlement du Canada reconnaît : Préambule

que le gouvernement du Canada n'entend pas par la présente loi abroger les pouvoirs, droits, privilèges ou autorités dévolus au Canada ou aux provinces sous le régime de la *Loi constitutionnelle de 1867* et de ses modifications ou à tout autre titre, ni leur déroger ou porter atteinte,

que les Canadiens ont fait des progrès remarquables, grâce à leur système de services de santé assurés, dans le traitement des maladies et le soulagement des affections et déficiences parmi toutes les catégories socio-économiques,

que les Canadiens peuvent encore améliorer leur bien-être en joignant à un mode de vie individuel axé sur la condition physique, la prévention des maladies et la promotion de la santé, une action collective contre les causes sociales, environnementales ou industrielles des maladies et qu'ils désirent un système de services de santé qui favorise la santé physique et mentale et la protection contre les maladies,

que les améliorations futures dans le domaine de la santé nécessiteront la coopération des gouvernements, des professionnels de la santé, des organismes bénévoles et des citoyens canadiens,

que l'accès continu à des soins de santé de qualité, sans obstacle financier ou autre, sera déterminant pour la conservation et l'amélio-

AND WHEREAS the Parliament of Canada wishes to encourage the development of health services throughout Canada by assisting the provinces in meeting the costs thereof;

NOW, THEREFORE, Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

ration de la santé et du bien-être des Canadiens;

considérant en outre que le Parlement du Canada souhaite favoriser le développement des services de santé dans tout le pays en aidant les provinces à en supporter le coût,

Sa Majesté, sur l'avis et avec le consentement du Sénat et de la Chambre des communes du Canada, édicte :

SHORT TITLE

Short title

1. This Act may be cited as the *Canada Health Act*. 1984, c. 6, s. 1.

TITRE ABRÉGÉ

Titre abrégé

1. *Loi canadienne sur la santé*. 1984, ch. 6, art. 1.

INTERPRETATION

Definitions

2. In this Act,

"Act of 1977" «*loi...*»

"Act of 1977" means the *Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act*;

"cash contribution" «*contribution pécuniaire*»

"cash contribution" means the amount of the established programs cash contribution referred to in paragraph 13(1)(*b*) of the Act of 1977 that is allocated by the Minister of Finance under section 19 of that Act in respect of the insured health services program of a province;

"contribution" «*contribution*»

"contribution" means the established programs financing contribution referred to in paragraphs 13(1)(*a*) and (*b*) of the Act of 1977 that may be provided to a province in respect of the insured health services program of the province;

"dentist" «*dentiste*»

"dentist" means a person lawfully entitled to practise dentistry in the place in which the practice is carried on by that person;

"extended health care services" «*services complémentaires...*»

"extended health care services" means the following services, as more particularly defined in the regulations, provided for residents of a province, namely,

(*a*) nursing home intermediate care service,

(*b*) adult residential care service,

(*c*) home care service, and

(*d*) ambulatory health care service;

"extra-billing" «*surfacturation*»

"extra-billing" means the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to

DÉFINITIONS

Définitions

2. Les définitions qui suivent s'appliquent à la présente loi.

«assuré» "*insured person*"

«assuré» Habitant d'une province, à l'exception :

a) des membres des Forces canadiennes;

b) des membres de la Gendarmerie royale du Canada nommés à un grade;

c) des personnes purgeant une peine d'emprisonnement dans un pénitencier, au sens de la *Loi sur les pénitenciers*;

d) des habitants de la province qui s'y trouvent depuis une période de temps inférieure au délai minimal de résidence ou de carence d'au plus trois mois imposé aux habitants par la province pour qu'ils soient admissibles ou aient droit aux services de santé assurés.

«contribution» "*contribution*"

«contribution» La contribution pour le financement des programmes établis visée aux alinéas 13(1)*a*) et *b*) de la loi de 1977 qui peut être versée à une province pour son programme de services de santé assurés.

«contribution pécuniaire» "*cash...*"

«contribution pécuniaire» La fraction de la contribution pour le financement des programmes établis visée à l'alinéa 13(1)*b*) de la loi de 1977 qui est payable comptant et affectée par le ministre des Finances en vertu de l'article 19 de cette loi au programme de services de santé assurés d'une province.

«dentiste» "*dentist*"

«dentiste» Personne légalement autorisée à exercer la médecine dentaire au lieu où elle se livre à cet exercice.

«frais modérateurs» "*user...*"

«frais modérateurs» Frais d'un service de santé assuré autorisés ou permis par un régime provincial d'assurance-santé mais non paya-

be paid for that service by the health care insurance plan of a province;

"health care insurance plan" *«régime...»*

"health care insurance plan" means, in relation to a province, a plan or plans established by the law of the province to provide for insured health services;

"health care practitioner" *«professionnel...»*

"health care practitioner" means a person lawfully entitled under the law of a province to provide health services in the place in which the services are provided by that person;

"hospital" *«hôpital»*

"hospital" includes any facility or portion thereof that provides hospital care, including acute, rehabilitative or chronic care, but does not include

(*a*) a hospital or institution primarily for the mentally disordered, or

(*b*) a facility or portion thereof that provides nursing home intermediate care service or adult residential care service, or comparable services for children;

"hospital services" *«services hospitaliers»*

"hospital services" means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely,

(*a*) accommodation and meals at the standard or public ward level and preferred accommodation if medically required,

(*b*) nursing service,

(*c*) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations,

(*d*) drugs, biologicals and related preparations when administered in the hospital,

(*e*) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,

(*f*) medical and surgical equipment and supplies,

(*g*) use of radiotherapy facilities,

(*h*) use of physiotherapy facilities, and

(*i*) services provided by persons who receive remuneration therefor from the hospital,

but does not include services that are excluded by the regulations;

"insured health services" *«services de santé...»*

"insured health services" means hospital services, physician services and surgical-dental

bles, soit directement soit indirectement, au titre d'un régime provincial d'assurance-santé, à l'exception des frais imposés par surfacturation.

«habitant» *"resident"*

«habitant» Personne domiciliée et résidant habituellement dans une province et légalement autorisée à être ou à rester au Canada, à l'exception d'une personne faisant du tourisme, de passage ou en visite dans la province.

«hôpital» *"hospital"*

«hôpital» Sont compris parmi les hôpitaux tout ou partie des établissements où sont fournis des soins hospitaliers, notamment aux personnes souffrant de maladie aiguë ou chronique ainsi qu'en matière de réadaptation, à l'exception :

a) des hôpitaux ou institutions destinés principalement aux personnes souffrant de troubles mentaux;

b) de tout ou partie des établissements où sont fournis des soins intermédiaires en maison de repos ou des soins en établissement pour adultes ou des soins comparables pour les enfants.

«loi de 1977» *"Act..."*

«loi de 1977» *Loi sur les arrangements fiscaux entre le gouvernement fédéral et les provinces et sur les contributions fédérales en matière d'enseignement postsecondaire et de santé.*

«médecin» *"medical..."*

«médecin» Personne légalement autorisée à exercer la médecine au lieu où elle se livre à cet exercice.

«ministre» *"Minister"*

«ministre» Le ministre de la Santé nationale et du Bien-être social.

«professionnel de la santé» *"health care practitioner"*

«professionnel de la santé» Personne légalement autorisée en vertu de la loi d'une province à fournir des services de santé au lieu où elle les fournit.

«régime d'assurance-santé» *"health care insurance..."*

«régime d'assurance-santé» Le régime ou les régimes constitués par la loi d'une province en vue de la prestation de services de santé assurés.

«services complémentaires de santé» *"extended..."*

«services complémentaires de santé» Les services définis dans les règlements et offerts aux habitants d'une province, à savoir :

a) les soins intermédiaires en maison de repos;

b) les soins en établissement pour adultes;

c) les soins à domicile;

d) les soins ambulatoires.

services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation;

"insured person" «*assuré*»

"insured person" means, in relation to a province, a resident of the province other than

(*a*) a member of the Canadian Forces,

(*b*) a member of the Royal Canadian Mounted Police who is appointed to a rank therein,

(*c*) a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, or

(*d*) a resident of the province who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services;

"medical practitioner" «*médecin*»

"medical practitioner" means a person lawfully entitled to practise medicine in the place in which the practice is carried on by that person;

"Minister" «*ministre*»

"Minister" means the Minister of National Health and Welfare;

"physician services" «*services médicaux*»

"physician services" means any medically required services rendered by medical practitioners;

"resident" «*habitant*»

"resident" means, in relation to a province, a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province;

"surgical-dental services" «*services de chirurgie...*»

"surgical-dental services" means any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures;

"user charge" «*frais...*»

"user charge" means any charge for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by a provincial health care insurance plan, but does not include any charge imposed by extra-billing. 1984, c. 6, ss. 2, 33.

«services de chirurgie dentaire» «*services de chirurgie dentaire*» "*surgical-dental...*"

«services de chirurgie dentaire» Actes de chirurgie dentaire nécessaires sur le plan médical ou dentaire, accomplis par un dentiste dans un hôpital, et qui ne peuvent être accomplis convenablement qu'en un tel établissement.

«services de santé assurés» «*services de santé assurés*» "*insured health...*"

«services de santé assurés» Services hospitaliers, médicaux ou de chirurgie dentaire fournis aux assurés, à l'exception des services de santé auxquels une personne a droit ou est admissible en vertu d'une autre loi fédérale ou d'une loi provinciale relative aux accidents du travail.

«services hospitaliers» «*services hospitaliers*» "*hospital services*"

«services hospitaliers» Services fournis dans un hôpital aux malades hospitalisés ou externes, si ces services sont médicalement nécessaires pour le maintien de la santé, la prévention des maladies ou le diagnostic ou le traitement des blessures, maladies ou invalidités, à savoir :

a) l'hébergement et la fourniture des repas en salle commune ou, si médicalement nécessaire, en chambre privée ou semi-privée;

b) les services infirmiers;

c) les actes de laboratoires, de radiologie ou autres actes de diagnostic, ainsi que les interprétations nécessaires;

d) les produits pharmaceutiques, substances biologiques et préparations connexes administrés à l'hôpital;

e) l'usage des salles d'opération, des salles d'accouchement et des installations d'anesthésie, ainsi que le matériel et les fournitures nécessaires;

f) le matériel et les fournitures médicaux et chirurgicaux;

g) l'usage des installations de radiothérapie;

h) l'usage des installations de physiothérapie;

i) les services fournis par les personnes rémunérées à cet effet par l'hôpital.

Ne sont pas compris parmi les services hospitaliers les services exclus par les règlements.

«services médicaux» «*services médicaux*» "*physician...*"

«services médicaux» Services médicalement nécessaires fournis par un médecin.

«surfacturation» «*surfactura*» "*extra-bill...*"

«surfacturation» Facturation de la prestation à un assuré par un médecin ou un dentiste d'un service de santé assuré, en excédent par rapport au montant payé ou à payer pour la prestation de ce service au titre du régime

provincial d'assurance-santé. 1984, ch. 6, art. 2 et 33.

CANADIAN HEALTH CARE POLICY

Primary objective of Canadian health care policy

3. It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers. 1984, c. 6, s. 3.

POLITIQUE CANADIENNE DE LA SANTÉ

Objectif premier

3. La politique canadienne de la santé a pour premier objectif de protéger, de favoriser et d'améliorer le bien-être physique et mental des habitants du Canada et de faciliter un accès satisfaisant aux services de santé, sans obstacles d'ordre financier ou autre. 1984, ch. 6, art. 3.

PURPOSE

Purpose of this Act

4. The purpose of this Act is to establish criteria and conditions that must be met before full payment may be made under the Act of 1977 in respect of insured health services and extended health care services provided under provincial law. 1984, c. 6, s. 4.

RAISON D'ÊTRE

Raison d'être de la présente loi

4. La présente loi a pour raison d'être d'établir des conditions d'octroi et de versement du plein montant prévu à la loi de 1977 à l'égard des services de santé assurés et des services complémentaires de santé fournis en vertu de la loi d'une province. 1984, ch. 6, art. 4.

CASH CONTRIBUTIONS AND PAYMENTS

Cash contribution

5. Subject to this Act, as part of the contribution provided by Canada to each province, a full cash contribution is payable under the Act of 1977 for each fiscal year in respect of the cost of insured health services provided under a health care insurance plan of the province. 1984, c. 6, s. 5.

CONTRIBUTIONS PÉCUNIAIRES ET VERSEMENTS

Contribution pécuniaire

5. Sous réserve des autres dispositions de la présente loi, le Canada verse pour chaque exercice, en vertu de la loi de 1977, comme fraction de sa contribution à chaque province, une pleine contribution pécuniaire à l'égard du coût des services de santé assurés fournis au titre d'un régime d'assurance-santé de la province. 1984, ch. 6, art. 5.

Amount payable for extended health care services

6. In addition to the cash contribution referred to in section 5, a full amount is payable by Canada to each province under section 23 of the Act of 1977 for each fiscal year in respect of the extended health care services program if the province complies with the conditions set out in section 13 of this Act. 1984, c. 6, s. 6.

Versement pour les services complémentaires de santé

6. En plus de la contribution pécuniaire visée à l'article 5, le Canada verse un plein montant à chaque province, pour chaque exercice, à l'égard du programme de services complémentaires de santé en vertu de l'article 23 de la loi de 1977, si la province se conforme aux conditions prévues à l'article 13 de la présente loi. 1984, ch. 6, art. 6.

PROGRAM CRITERIA

Program criteria

7. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters:

(*a*) public administration;

(*b*) comprehensiveness;

(*c*) universality;

(*d*) portability; and

(*e*) accessibility. 1984, c. 6, s. 7.

CONDITIONS D'OCTROI

Règle générale

7. Le versement à une province, pour un exercice, de la pleine contribution pécuniaire visée à l'article 5 est assujetti à l'obligation pour le régime d'assurance-santé de satisfaire, pendant tout cet exercice, aux conditions d'octroi énumérées aux articles 8 à 12 quant à :

a) la gestion publique;

b) l'intégralité;

c) l'universalité;

d) la transférabilité;

e) l'accessibilité. 1984, ch. 6, art. 7.

Public administration

8. (1) In order to satisfy the criterion respecting public administration,

(*a*) the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province;

(*b*) the public authority must be responsible to the provincial government for that administration and operation; and

(*c*) the public authority must be subject to audit of its accounts and financial transactions by such authority as is charged by law with the audit of the accounts of the province.

Gestion publique

8. (1) La condition de gestion publique suppose que :

a) le régime provincial d'assurance-santé soit géré sans but lucratif par une autorité publique nommée ou désignée par le gouvernement de la province;

b) l'autorité publique soit responsable devant le gouvernement provincial de cette gestion;

c) l'autorité publique soit assujettie à la vérification de ses comptes et de ses opérations financières par l'autorité chargée par la loi de la vérification des comptes de la province.

Designation of agency permitted

(2) The criterion respecting public administration is not contravened by reason only that the public authority referred to in subsection (1) has the power to designate any agency

(*a*) to receive on its behalf any amounts payable under the provincial health care insurance plan; or

(*b*) to carry out on its behalf any responsibility in connection with the receipt or payment of accounts rendered for insured health services, if it is a condition of the designation that all those accounts are subject to assessment and approval by the public authority and that the public authority shall determine the amounts to be paid in respect thereof. 1984, c. 6, s. 8.

Désignation d'un mandataire

(2) La condition de gestion publique n'est pas enfreinte du seul fait que l'autorité publique visée au paragraphe (1) a le pouvoir de désigner un mandataire chargé :

a) soit de recevoir en son nom les montants payables au titre du régime provincial d'assurance-santé;

b) soit d'exercer en son nom les attributions liées à la réception ou au règlement des comptes remis pour prestation de services de santé assurés si la désignation est assujettie à la vérification et à l'approbation par l'autorité publique des comptes ainsi remis et à la détermination par celle-ci des montants à payer à cet égard. 1984, ch. 6, art. 8.

Comprehensiveness

9. In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners. 1984, c. 6, s. 9.

Intégralité

9. La condition d'intégralité suppose qu'au titre du régime provincial d'assurance-santé, tous les services de santé assurés fournis par les hôpitaux, les médecins ou les dentistes soient assurés, et lorsque la loi de la province le permet, les services semblables ou additionnels fournis par les autres professionnels de la santé. 1984, ch. 6, art. 9.

Universality

10. In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions. 1984, c. 6, s. 10.

Universalité

10. La condition d'universalité suppose qu'au titre du régime provincial d'assurance-santé, cent pour cent des assurés de la province ait droit aux services de santé assurés prévus par celui-ci, selon des modalités uniformes. 1984, ch. 6, art. 10.

Portability

11. (1) In order to satisfy the criterion respecting portability, the health care insurance plan of a province

(*a*) must not impose any minimum period of residence in the province, or waiting period,

Transférabilité

11. (1) La condition de transférabilité suppose que le régime provincial d'assurance-santé :

a) n'impose pas de délai minimal de résidence ou de carence supérieur à trois mois

in excess of three months before residents of the province are eligible for or entitled to insured health services;

(*b*) must provide for and be administered and operated so as to provide for the payment of amounts for the cost of insured health services provided to insured persons while temporarily absent from the province on the basis that

(i) where the insured health services are provided in Canada, payment for health services is at the rate that is approved by the health care insurance plan of the province in which the services are provided, unless the provinces concerned agree to apportion the cost between them in a different manner, or

(ii) where the insured health services are provided out of Canada, payment is made on the basis of the amount that would have been paid by the province for similar services rendered in the province, with due regard, in the case of hospital services, to the size of the hospital, standards of service and other relevant factors; and

(*c*) must provide for and be administered and operated so as to provide for the payment, during any minimum period of residence, or any waiting period, imposed by the health care insurance plan of another province, of the cost of insured health services provided to persons who have ceased to be insured persons by reason of having become residents of that other province, on the same basis as though they had not ceased to be residents of the province.

aux habitants de la province pour qu'ils soient admissibles ou aient droit aux services de santé assurés;

b) prévoie et que ses modalités d'application assurent le paiement des montants pour le coût des services de santé assurés fournis à des assurés temporairement absents de la province :

(i) si ces services sont fournis au Canada, selon le taux approuvé par le régime d'assurance-santé de la province où ils sont fournis, sauf accord de répartition différente du coût entre les provinces concernées,

(ii) s'il sont fournis à l'étranger, selon le montant qu'aurait versé la province pour des services semblables fournis dans la province, compte tenu, s'il s'agit de services hospitaliers, de l'importance de l'hôpital, de la qualité des services et des autres facteurs utiles;

c) prévoie et que ses modalités d'application assurent la prise en charge, pendant le délai minimal de résidence ou de carence imposé par le régime d'assurance-santé d'une autre province, du coût des services de santé assurés fournis aux personnes qui ne sont plus assurées du fait qu'elles habitent cette province, dans les mêmes conditions que si elles habitaient encore leur province d'origine.

Requirement for consent for elective insured health services permitted

(2) The criterion respecting portability is not contravened by a requirement of a provincial health care insurance plan that the prior consent of the public authority that administers and operates the plan must be obtained for elective insured health services provided to a resident of the province while temporarily absent from the province if the services in question were available on a substantially similar basis in the province.

Consentement préalable à la prestation des services de santé assurés facultatifs

(2) La condition de transférabilité n'est pas enfreinte du fait qu'il faut, aux termes du régime d'assurance-santé d'une province, le consentement préalable de l'autorité publique qui le gère pour la prestation de services de santé assurés facultatifs à un habitant temporairement absent de la province, si ces services y sont offerts selon des modalités sensiblement comparables.

Definition of "elective insured health services"

(3) For the purpose of subsection (2), "elective insured health services" means insured health services other than services that are provided in an emergency or in any other circumstance in which medical care is required without delay. 1984, c. 6, s. 11.

Définition de «services de santé assurés facultatifs»

(3) Pour l'application du paragraphe (2), «services de santé assurés facultatifs» s'entend des services de santé assurés, à l'exception de ceux qui sont fournis d'urgence ou dans d'autres circonstances où des soins médicaux sont requis sans délai. 1984, ch. 6, art. 11.

Accessibility

12. (1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province

(*a*) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;

(*b*) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;

(*c*) must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and

(*d*) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.

Reasonable compensation

(2) In respect of any province in which extra-billing is not permitted, paragraph (1)(*c*) shall be deemed to be complied with if the province has chosen to enter into, and has entered into, an agreement with the medical practitioners and dentists of the province that provides

(*a*) for negotiations relating to compensation for insured health services between the province and provincial organizations that represent practising medical practitioners or dentists in the province;

(*b*) for the settlement of disputes relating to compensation through, at the option of the appropriate provincial organizations referred to in paragraph (*a*), conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman; and

(*c*) that a decision of a panel referred to in paragraph (*b*) may not be altered except by an Act of the legislature of the province. 1984, c. 6, s. 12.

Accessibilité

12. (1) La condition d'accessibilité suppose que le régime provincial d'assurance-santé :

a) offre les services de santé assurés selon des modalités uniformes et ne fasse pas obstacle, directement ou indirectement, et notamment par facturation aux assurés, à un accès satisfaisant par eux à ces services;

b) prévoie la prise en charge des services de santé assurés selon un tarif ou autre mode de paiement autorisé par la loi de la province;

c) prévoie une rémunération raisonnable de tous les services de santé assurés fournis par les médecins ou les dentistes;

d) prévoie le versement de montants aux hôpitaux, y compris les hôpitaux que possède ou gère le Canada, à l'égard du coût des services de santé assurés.

Rémunération raisonnable

(2) Pour toute province où la surfacturation n'est pas permise, il est réputé être satisfait à l'alinéa (1)*c*) si la province a choisi de conclure un accord et a effectivement conclu un accord avec ses médecins et dentistes prévoyant :

a) la tenue de négociations sur la rémunération des services de santé assurés entre la province et les organisations provinciales représentant les médecins ou dentistes qui exercent dans la province;

b) le règlement des différends concernant la rémunération par, au choix des organisations provinciales compétentes visées à l'alinéa *a*), soit la conciliation soit l'arbitrage obligatoire par un groupe représentant également les organisations provinciales et la province et ayant un président indépendant;

c) l'impossibilité de modifier la décision du groupe visé à l'alinéa *b*), sauf par une loi de la province. 1984, ch. 6, art. 12.

CONDITIONS FOR CASH CONTRIBUTIONS OR PAYMENTS

CONDITIONS DE VERSEMENT

Conditions

13. In order that a province may qualify for a full cash contribution referred to in section 5 or payment of the full amount referred to in section 6 for a fiscal year, the government of the province

Obligations de la province

13. Le versement à une province, pour un exercice, de la pleine contribution pécuniaire visée à l'article 5 ou du plein montant visé à l'article 6 est assujetti à l'obligation pour le gouvernement de la province :

(*a*) shall, at the times and in the manner prescribed by the regulations, provide the Minister with such information, of a type prescribed by the regulations, as the Minister may reasonably require for the purposes of this Act; and

(*b*) shall give recognition to the contributions and payments by Canada under this Act in any public documents, or in any advertising or promotional material, relating to insured health services and extended health care services in the province. 1984, c. 6, s. 13.

a) de communiquer au ministre, selon les modalités de temps et autres prévues par les règlements, les renseignements du genre prévu aux règlements, dont celui-ci peut normalement avoir besoin pour l'application de la présente loi;

b) de faire état des contributions et montants versés par le Canada en vertu de la présente loi dans tout document public ou toute publicité sur les services de santé assurés et les services complémentaires de santé dans la province. 1984, ch. 6, art. 13.

DEFAULTS

MANQUEMENTS

Referral to Governor in Council

14. (1) Subject to subsection (3), where the Minister, after consultation in accordance with subsection (2) with the minister responsible for health care in a province, is of the opinion that

(*a*) the health care insurance plan of the province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12, or

(*b*) the province has failed to comply with any condition set out in section 13,

and the province has not given an undertaking satisfactory to the Minister to remedy the default within a period that the Minister considers reasonable, the Minister shall refer the matter to the Governor in Council.

Renvoi au gouverneur en conseil

14. (1) Sous réserve du paragraphe (3), dans le cas où il estime, après avoir consulté conformément au paragraphe (2) son homologue chargé de la santé dans une province :

a) soit que le régime d'assurance-santé de la province ne satisfait pas ou plus aux conditions visées aux articles 8 à 12;

b) soit que la province ne s'est pas conformée aux conditions visées à l'article 13,

et que celle-ci ne s'est pas engagée de façon satisfaisante à remédier à la situation dans un délai suffisant, le ministre renvoie l'affaire au gouverneur en conseil.

Consultation process

(2) Before referring a matter to the Governor in Council under subsection (1) in respect of a province, the Minister shall

(*a*) send by registered mail to the minister responsible for health care in the province a notice of concern with respect to any problem foreseen;

(*b*) seek any additional information available from the province with respect to the problem through bilateral discussions, and make a report to the province within ninety days after sending the notice of concern; and

(*c*) if requested by the province, meet within a reasonable period of time to discuss the report.

Étapes de la consultation

(2) Avant de renvoyer une affaire au gouverneur en conseil conformément au paragraphe (1) relativement à une province, le ministre :

a) envoie par courrier recommandé à son homologue chargé de la santé dans la province un avis sur tout problème éventuel;

b) tente d'obtenir de la province, par discussions bilatérales, tout renseignement additionnel disponible sur le problème et fait rapport à la province dans les quatre-vingt-dix jours suivant l'envoi de l'avis;

c) si la province le lui demande, tient une réunion dans un délai acceptable afin de discuter du rapport.

Where no consultation can be achieved

(3) The Minister may act without consultation under subsection (1) if the Minister is of the opinion that a sufficient time has expired after reasonable efforts to achieve consultation and that consultation will not be achieved. 1984, c. 6, s. 14.

Impossibilité de consultation

(3) Le ministre peut procéder au renvoi prévu au paragraphe (1) sans consultation préalable s'il conclut à l'impossibilité d'obtenir cette consultation malgré des efforts sérieux déployés à cette fin au cours d'un délai convenable. 1984, ch. 6, art. 14.

Order reducing or withholding contribution

15. (1) Where, on the referral of a matter under section 14, the Governor in Council is of the opinion that the health care insurance plan of a province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12 or that a province has failed to comply with any condition set out in section 13, the Governor in Council may, by order,

(*a*) direct that any cash contribution or amount payable to that province for a fiscal year be reduced, in respect of each default, by an amount that the Governor in Council considers to be appropriate, having regard to the gravity of the default; or

(*b*) where the Governor in Council considers it appropriate, direct that the whole of any cash contribution or amount payable to that province for a fiscal year be withheld.

Décret de réduction ou de retenue

15. (1) Si l'affaire lui est renvoyée en vertu de l'article 14 et qu'il estime que le régime d'assurance-santé de la province ne satisfait pas ou plus aux conditions visées aux articles 8 à 12 ou que la province ne s'est pas conformée aux conditions visées à l'article 13, le gouverneur en conseil peut, par décret :

a) soit ordonner, pour chaque manquement, que les contributions pécuniaires ou versements d'un exercice à la province soient réduits du montant qu'il estime indiqué, compte tenu de la gravité du manquement;

b) soit, s'il l'estime indiqué, ordonner la retenue de la totalité des contributions pécuniaires ou versements d'un exercice à la province.

Amending orders

(2) The Governor in Council may, by order, repeal or amend any order made under subsection (1) where the Governor in Council is of the opinion that the repeal or amendment is warranted in the circumstances.

Modification des décrets

(2) Le gouverneur en conseil peut, par décret, annuler ou modifier un décret pris en vertu du paragraphe (1) s'il l'estime justifié dans les circonstances.

Notice of order

(3) A copy of each order made under this section together with a statement of any findings on which the order was based shall be sent forthwith by registered mail to the government of the province concerned and the Minister shall cause the order and statement to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the order is made.

Avis

(3) Le texte de chaque décret pris en vertu du présent article de même qu'un exposé des motifs sur lesquels il est fondé sont envoyés sans délai par courrier recommandé au gouvernement de la province concernée; le ministre fait déposer le texte du décret et celui de l'exposé devant chaque chambre du Parlement dans les quinze premiers jours de séance de celle-ci suivant la prise du décret.

Commencement of order

(4) An order made under subsection (1) shall not come into force earlier than thirty days after a copy of the order has been sent to the government of the province concerned under subsection (3). 1984, c. 6, s. 15.

Entrée en vigueur du décret

(4) Un décret pris en vertu du paragraphe (1) ne peut entrer en vigueur que trente jours après l'envoi au gouvernement de la province concernée du texte du décret aux termes du paragraphe (3). 1984, ch. 6, art. 15.

Reimposition of reductions or withholdings

16. In the case of a continuing failure to satisfy any of the criteria described in sections 8 to 12 or to comply with any condition set out in section 13, any reduction or withholding under section 15 of a cash contribution or an amount payable to a province for a fiscal year shall be reimposed for each succeeding fiscal year as long as the Minister is satisfied, after consultation with the minister responsible for health care in the province, that the default is continuing. 1984, c. 6, s. 16.

Nouvelle application des réductions ou retenues

16. En cas de manquement continu aux conditions visées aux articles 8 à 12 ou à l'article 13, les réductions ou retenues des contributions pécuniaires ou des versements à une province déjà appliquées pour un exercice en vertu de l'article 15 lui sont appliquées de nouveau pour chaque exercice ultérieur où le ministre estime, après consultation de son homologue chargé de la santé dans la province, que le manquement se continue. 1984, ch. 6, art. 16.

When reduction or withholding imposed

17. Any reduction or withholding under section 15 or 16 of a cash contribution or payment may be imposed in the fiscal year in which the

Application aux exercices ultérieurs

17. Toute réduction ou retenue d'une contribution pécuniaire ou d'un versement visée aux articles 15 ou 16 peut être appliquée pour

default that gave rise to the reduction or withholding occurred or in the following fiscal year. 1984, c. 6, s. 17.

l'exercice où le manquement à son origine a eu lieu ou pour l'exercice suivant. 1984, ch. 6, art. 17.

EXTRA-BILLING AND USER CHARGES

SURFACTURATION ET FRAIS MODÉRATEURS

Extra-billing

18. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, no payments may be permitted by the province for that fiscal year under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists. 1984, c. 6, s. 18.

Surfacturation

18. Une province n'a droit, pour un exercice, à la pleine contribution pécuniaire visée à l'article 5 que si, aux termes de son régime d'assurance-santé, elle ne permet pas pour cet exercice le versement de montants à l'égard des services de santé assurés qui ont fait l'objet de surfacturation par les médecins ou les dentistes. 1984, ch. 6, art. 18.

User charges

19. (1) In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, user charges must not be permitted by the province for that fiscal year under the health care insurance plan of the province.

Frais modérateurs

19. (1) Une province n'a droit, pour un exercice, à la pleine contribution pécuniaire visée à l'article 5 que si, aux termes de son régime d'assurance-santé, elle ne permet pas pour cet exercice l'imposition d'aucuns frais modérateurs.

Limitation

(2) Subsection (1) does not apply in respect of user charges for accommodation or meals provided to an in-patient who, in the opinion of the attending physician, requires chronic care and is more or less permanently resident in a hospital or other institution. 1984, c. 6, s. 19.

Réserve

(2) Le paragraphe (1) ne s'applique pas aux frais modérateurs imposés pour l'hébergement ou les repas fournis à une personne hospitalisée qui, de l'avis du médecin traitant, souffre d'une maladie chronique et séjourne de façon plus ou moins permanente à l'hôpital ou dans une autre institution. 1984, ch. 6, art. 19.

Deduction for extra-billing

20. (1) Where a province fails to comply with the condition set out in section 18, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged through extra-billing by medical practitioners or dentists in the province in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Déduction en cas de surfacturation

20. (1) Dans le cas où une province ne se conforme pas à la condition visée à l'article 18, il est déduit de la contribution pécuniaire à cette dernière pour un exercice un montant, déterminé par le ministre d'après les renseignements fournis conformément aux règlements, égal au total de la surfacturation effectuée par les médecins ou les dentistes dans la province pendant l'exercice ou, si les renseignements n'ont pas été fournis conformément aux règlements, un montant estimé par le ministre égal à ce total.

Deduction for user charges

(2) Where a province fails to comply with the condition set out in section 19, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged in the province in respect of user charges to which section 19 applies in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Déduction en cas de frais modérateurs

(2) Dans le cas où une province ne se conforme pas à la condition visée à l'article 19, il est déduit de la contribution pécuniaire à cette dernière pour un exercice un montant, déterminé par le ministre d'après les renseignements fournis conformément aux règlements, égal au total des frais modérateurs assujettis à l'article 19 imposés dans la province pendant l'exercice ou, si les renseignements n'ont pas été fournis conformément aux règlements, un montant estimé par le ministre égal à ce total.

Consultation with province

(3) The Minister shall not estimate an amount under subsection (1) or (2) without first undertaking to consult the minister responsible for health care in the province concerned.

Consultation de la province

(3) Avant d'estimer un montant visé au paragraphe (1) ou (2), le ministre se charge de consulter son homologue responsable de la santé dans la province concernée.

Separate accounting in Public Accounts

(4) Any amount deducted under subsection (1) or (2) from a cash contribution in any of the three consecutive fiscal years the first of which commences on April 1, 1984 shall be accounted for separately in respect of each province in the Public Accounts for each of those fiscal years in and after which the amount is deducted.

Comptabilisation

(4) Les montants déduits d'une contribution pécuniaire en vertu des paragraphes (1) ou (2) pendant les trois exercices consécutifs dont le premier commence le 1er avril 1984 sont comptabilisés séparément pour chaque province dans les comptes publics pour chacun de ces exercices pendant et après lequel le montant a été déduit.

Refund to province

(5) Where, in any of the three fiscal years referred to in subsection (4), extra-billing or user charges have, in the opinion of the Minister, been eliminated in a province, the total amount deducted in respect of extra-billing or user charges, as the case may be, shall be paid to the province.

Remboursement à la province

(5) Si, de l'avis du ministre, la surfacturation ou les frais modérateurs ont été supprimés dans une province pendant l'un des trois exercices visés au paragraphe (4), il est versé à cette dernière le montant total déduit à l'égard de la surfacturation ou des frais modérateurs, selon le cas.

Saving

(6) Nothing in this section restricts the power of the Governor in Council to make any order under section 15. 1984, c. 6, s. 20.

Réserve

(6) Le présent article n'a pas pour effet de limiter le pouvoir du gouverneur en conseil de prendre le décret prévu à l'article 15. 1984, ch. 6, art. 20.

When deduction made

21. Any deduction from a cash contribution under section 20 may be made in the fiscal year in which the matter that gave rise to the deduction occurred or in the following two fiscal years. 1984, c. 6, s. 21.

Application aux exercices ultérieurs

21. Toute déduction d'une contribution pécuniaire visée à l'article 20 peut être appliquée pour l'exercice où le fait à son origine a eu lieu ou pour les deux exercices suivants. 1984, ch. 6, art. 21.

REGULATIONS

RÈGLEMENTS

Regulations

22. (1) Subject to this section, the Governor in Council may make regulations for the administration of this Act and for carrying its purposes and provisions into effect, including, without restricting the generality of the foregoing, regulations

(*a*) defining the services referred to in paragraphs (*a*) to (*d*) of the definition "extended health care services" in section 2;

(*b*) prescribing the services excluded from hospital services;

(*c*) prescribing the types of information that the Minister may require under paragraph 13(*a*) and the times at which and the manner in which that information shall be provided; and

(*d*) prescribing the manner in which recognition to contributions and payments by Canada under this Act is required to be given under paragraph 13(*b*).

Règlements

22. (1) Sous réserve des autres dispositions du présent article, le gouverneur en conseil peut, par règlement, prendre toute mesure d'application de la présente loi et, notamment :

a) définir les services visés aux alinéas *a*) à *d*) de la définition de «services complémentaires de santé» à l'article 2;

b) déterminer les services exclus des services hospitaliers;

c) déterminer les genres de renseignements dont peut avoir besoin le ministre en vertu de l'alinéa 13*a*) et fixer les modalités de temps et autres de leur communication;

d) prévoir la façon dont il doit être fait état en vertu de l'alinéa 13*b*) des contributions et montants versés par le Canada en vertu de la présente loi.

greement of ovinces

(2) Subject to subsection (3), no regulation may be made under paragraph (1)(*a*) or (*b*) except with the agreement of each of the provinces.

(2) Sous réserve du paragraphe (3), il ne peut être pris de règlements en vertu des alinéas (1)*a*) ou *b*) qu'avec l'accord de chaque province.

Consentement des provinces

ception

(3) Subsection (2) does not apply in respect of regulations made under paragraph (1)(*a*) if they are substantially the same as regulations made under the Act of 1977, as it read immediately prior to April 1, 1984.

(3) Le paragraphe (2) ne s'applique pas aux règlements pris en vertu de l'alinéa (1)*a*) s'ils sont sensiblement comparables aux règlements pris en vertu de la loi de 1977, dans sa version précédant immédiatement le 1er avril 1984.

Exception

nsultation h provinces

(4) No regulation may be made under paragraph (1)(*c*) or (*d*) unless the Minister has first consulted with the ministers responsible for health care in the provinces. 1984, c. 6, s. 22.

(4) Il ne peut être pris de règlements en vertu des alinéas (1)*c*) ou *d*) que si le ministre a au préalable consulté ses homologues chargés de la santé dans les provinces. 1984, ch. 6, art. 22.

Consultation des provinces

REPORT TO PARLIAMENT

RAPPORT AU PARLEMENT

nual report Minister

23. The Minister shall, as soon as possible after the termination of each fiscal year and in any event not later than December 31 of the next fiscal year, make a report respecting the administration and operation of this Act for that fiscal year, including all relevant information on the extent to which provincial health care insurance plans have satisfied the criteria, and the extent to which the provinces have satisfied the conditions, for payment under this Act and shall cause the report to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the report is completed. 1984, c. 6, s. 23.

23. Au plus tard pour le 31 décembre de chaque année, le ministre établit dans les meilleurs délais un rapport sur l'application de la présente loi au cours du précédent exercice, en y incluant notamment tous les renseignements pertinents sur la mesure dans laquelle les régimes provinciaux d'assurance-santé et les provinces ont satisfait aux conditions d'octroi et de versement prévues à la présente loi; le ministre fait déposer le rapport devant chaque chambre du Parlement dans les quinze premiers jours de séance de celle-ci suivant son achèvement. 1984, ch. 6, art. 23.

Rapport annuel du ministre

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